August 23, 2012

BEFORE THE FEDERAL COMMUNICATIONS COMMISSION

Rural Health Care Reform Proceeding	)	WC Docket No. 02-60
	)	
Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding	)	DA 12-1166

Comments of the Montana Telecommunications Association

Introduction

The Montana Telecommunications Association ("MTA") appreciates the opportunity to respond to the Federal Communications Commission's ("Commission") request for further comment on issues in the Rural Health Care Reform Proceeding.

MTA has filed a number of comments pertaining to the Rural Health Care Program and Rural Health Care Pilot Program and the Reform Proceeding.[1] In particular, MTA consistently has opposed the funding of infrastructure construction under the Rural Health Care Program, as proposed in the Rural Health Care Reform Notice of Proposed Rulemaking.

[1] For example, see *inter alia*.: *In the Matter of Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking. WC Docket No. 02-60. Comments of the Montana Telecommunications Association. September 10, 2010. Reply Comments, September 23, 2010. *In the Matter of Health Care Delivery Elements of the National Broadband Plan*. Docket Nos. GN 09-51 and WC 02-60. Comments of the Montana Telecommunications Association. January 11, 2010. *Ex parte* comments filed on January 29, 2010; October 27, 2010; January 30, 2011; May 3, 2011.

Section III.c.—Limited Funding for Construction of Facilities in Broadband Services Program.[2]

It is important first to review the statute in its entirety as it pertains to establishment of the Rural Health Care Program. Section 254(h) of the Telecommunications Act of 1996 (47 U.S.C. §254(h)) states:

(h) TELECOMMUNICATIONS SERVICES FOR CERTAIN PROVIDERS.—

(1) IN GENERAL.—

(A) HEALTH CARE PROVIDERS FOR RURAL AREAS.—A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State. A telecommunications carrier providing service under this paragraph shall be entitled to have an amount equal to the difference, if any, between the rates for service provided to health care providers for rural areas in a State and the rates of similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a apart of its obligation to participate in the mechanisms to preserve and advance universal service….

(2) ADVANCED SERVICES.—The Commission shall establish competitively neutral rules—

(A) to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit elementary and secondary school classrooms, health care provider, and libraries; and

(B) to define the circumstances under which a telecommunications carrier may be required to connect its network to such public institutional telecommunications users.

(3) TERMS AND CONDITIONS.—Telecommunications services and network capacity provided to a public institutional telecommunications user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value.

(4) ELIGIBILITY OF USERS.—No entity listed in this subsection shall be entitled to preferential rates or treatment as required by this subsection, if

[2] As explained, *infra*, construction of facilities is distinct from provision broadband services. Thus, the title of Sec. III.c. is misleading since the NPRM separates the proposed "*Infrastructure* Program," which MTA opposes, from the proposed "Broadband *Services* Program." The title for Sec. III.c. seems to infer that the Commission intends to "merge" the proposed Infrastructure Program and the Broadband Services Program. Any use of universal service health care funds for construction of telecommunications infrastructure by health care providers, as discussed herein, is ill-advised at best.

such entity operates as a for-profit business, is a school described in paragraph (5)(A) with an endowment of more than $50,000,000 or is a library not eligible for participation in State-based plans for funds under title III of the Library Services and Construction Act (20 U.S.C. 335c et seq.)…

(7) DEFINITIONS.—For purposes of this subsection:…

(B) HEALTH CARE PROVIDER.—The term "health care provider" means—

(i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;

(ii) community health centers or health centers providing health care to migrants;

(iii) local health departments or agencies;

(iv) community mental health centers;

(v) not-for-profit hospitals;

(vi) rural health clinics; and

(vii) consortia of health care providers consisting of one or more entities described in clauses (i) through (vi).

(C) PUBLIC INSTITUTIONAL TELECOMMUNICATIONS USER.—The term "public institutional telecommunications user" means an elementary or secondary school, a library, or a health care provider as those terms are defined in this paragraph.

In short, the Telecommunications Act does not authorize the use of universal service funds for the construction of health care network facilities (i.e., infrastructure) under the Rural Health Care Program.

The fact that Congress did not authorize the construction, or sale, of infrastructure under the Rural Health Care Program happens to be good policy. Even if somehow the statute were construed to permit construction of telecommunications infrastructure under the Rural Health Care Program, MTA, among others, has pointed out that such a policy is inappropriate at best.

The American Telemedicine Association has commented that "the use of universal service healthcare funds to support broadband infrastructure construction is ill advised. These universal service funds can be better used to support the ongoing delivery of healthcare services."[3]

[3] *In the Matter of Notice of Proposed Rulemaking Regarding the Universal Service Support Mechanism for Rural Healthcare*. WC Docket No. 02-60. Comments of the American Telemedicine Association on the Further Notice of Proposed Rulemaking. September 8, 2010. p. 3.

The Commission's Wireline Competition Bureau ("WCB") further points out that

> The majority of Pilot projects have created successful broadband networks by purchasing broadband services from a third party, rather than constructing and owning their own broadband facilities. Mechanisms such as long-term leases, prepaid leases, and indefeasible rights of use of facilities for specified period of time (IRUs) help many projects obtain the bandwidth and service quality they need.[4]

The WCB Report further notes that only eight of fifty pilot projects (16%) used Pilot Program support for construction, and only two of those projects (4%) constructed their entire networks.[5] The rest of the projects opted instead to purchase services. For example, "the Colorado Telehealth Network stated that it was able to include more providers on its network through purchasing services than if it chose to construct and own its network.[6] Additional data indicate that it is more efficient to purchase services than to build facilities. For example, while 16% of the pilot projects used funds to construct networks, they comprise 25% of the amounts awarded in the pilot program ($105 million of $417.7 million total awards). Using funding commitments as opposed to total awards,[7] the WCB Report finds that the cost per month per health care provider is nearly 50% greater for constructed facilities as opposed to leased/purchased facilities ($830

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[4] Wireline Competition Bureau. *Evaluation of Rural Health Care Pilot Program*. Staff Report. WC Docket No. 02-60; DA 12-1332. August 13, 2012. p. 4. ("WCB Report")

[5] *Id*. p. 30.

[6] *Id*. fn. 144.

[7] Data based on *funding commitments* presents an incomplete picture of pilot program funding. Funding commitments currently total about $273 million, while funds awarded total $417 million. It is likely that after all funding is requested and committed to rural health care pilot projects, the total amount awarded will be approximately $375 million, or more. MTA believes that *total award* data depict even greater inefficiencies attributable to infrastructure construction. For example, the WCB Report notes that the Health Information Exchange of Montana (HIEM) accounts for $7.4 million in funds *committed*. However, HIEM has been *awarded* $13.6 million and in fact has requested funding beyond the initial award amount. (See *Wireline Competition Bureau Seeks Comment on Health Information Exchange of Montana Request for Additional Funding under the Rural Health Care Pilot Program*. WC Docket No. 02-60; DA 11-95. January 19, 2011. See also, MTA Comments, February 18, 2011.) As noted in previous MTA comments, another Pilot Program project in Montana, the Frontier Access to Rural Healthcare in Montana (FAhRM) is designed to reach a greater number of health care providers over a far larger and less densely populated land area of Montana, for 14% of the cost of the HIEM network ($1.96 million vs. $13.6 million in total awarded funds).

per month per health care provider vs. $560 per month per provider for the Primary Program).[8]

The Commission's Public Notice ("PN") further confirms that using rural health care funds for infrastructure construction is less advantageous than funding broadband services.

> Projects chose to lease services instead of building networks because HCPs did not want to own or manage the networks and could more easily obtain needed broadband without owning the facilities or incurring administrative and other costs associated with network ownership. In light of the number of successful projects that elected to lease services instead of constructing networks, this Public Notice focuses on deepening the record regarding the Commission's proposed Broadband Services Program and the participation by consortia, including Pilot projects, in such a program.[9]

The PN further cites observations of the Universal Service Administrative Company ("USAC"), which are based on a number of interviews and other meetings with pilot projects.

> The projects choosing to lease services cite several reasons for that choice, including that HCPs' core competencies does not include owning or managing communications networks, that HCPs can obtain the needed broadband without owning the facilities themselves,[10] and that the administrative and other costs associated with broadband network ownership are too great.[11]

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[8] *Op cit*. p. 32. MTA further notes that the cost of leased services continues to decline, particularly when measured on a per-megabit basis. The gap between build vs. lease costs is likely to grow wider over time.

[9] *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*. Public Notice ("PN"). WC Docket No. 02-60; DA 12-1166. July 19, 2012. ¶ 3.

[10] See also, the Commission's Omnibus Broadband Initiative ("OBI") Technical Paper #5, which found, using data that is at least two years old now, that barely more than one percent ("an estimated 3,600 out of approximately 307,000 small [rural heath care] providers") faced a "broadband connectivity gap." Dedicated Internet access ("DIA"), such as DS3 or Gigabit Ethernet service "is available everywhere. Broadband service providers offer customized solutions for customers who were wiling to pay for them, no matter where they are located…therefore, the major barrier for medium and large providers is not access—it is price."

[11] *Op cit*. (PN). ¶ 9.

Despite these observations, the PN asks "whether it would be appropriate under the proposed Broadband Services Program, if adopted, to provide funding to recipients to construct and own network facilities under limited circumstances."[12] Notwithstanding the fact that such construction is not authorized by the Act, as discussed above, MTA has observed that any determination of when broadband service or facilities might be unavailable—thereby "justifying" network construction and ownership by health care providers—has been demonstrated to be a highly problematic exercise. For example, one health care pilot project in Montana asserted that broadband facilities were lacking, and thus the project needed to build its own network facilities. In fact, broadband facilities, including fiber optic connections directly to the pilot project's partners, were currently available at the time the pilot project applicant asserted otherwise. The pilot project declined to use these existing facilities or to enter into long term lease arrangements with existing network providers. Given this experience, MTA finds it hard to conceive of proper safeguards to recommend to prevent such duplication of network infrastructure by any future health care construction projects, even if such construction were lawful.

Sec. III.10.d.—Ineligible sites and treatment of shared services/costs.

The PN also notes that §254(h)(3) "*restricts* the resale of any services purchased pursuant to the rural health care support mechanism." (Emphasis added.) Despite this "restriction," the Pilot Program permitted the sale to ineligible entities of "excess network capacity" on networks built by rural health care providers under the rural health care Pilot Program mechanism "as long as the ineligible entity paid its 'fair share' of network costs attributable to the portion of the network capacity used."[13] First, the Act *prohibits* (as opposed to "*restricts*") the resale of any services purchased pursuant to the rural health care support mechanism. Second, any "excess capacity" results from the construction of

[12] *Id*. Sec. III.c.
[13] *Id*. Sec. III.d.

networks whose initial funding is not authorized by the Act. Thus, the construction of "excess capacity" is not authorized in the first place, and the sale of such capacity is prohibited.

Sec. IV.—Competitive Bidding Process and Related Matters

MTA finds reasonable—and lawful—many of the proposed reform recommendations discussed in this Section, including rural health care providers' "use of long-term prepaid leases and indefeasible rights-of-use (IRU) arrangements" including funding for the lease of lit or dark fiber.[14] As the PN notes, "most stakeholders prefer not to own the physical facilities comprising their network, but would rather defer to service providers that have experience and expertise in these matters…"[15] Long term leases, IRUs, and fiber arrangements are tools of the trade that telecommunications providers are willing to negotiate with any interested rural health care provider.

The WCB Report summarizes this point in discussing the benefits of prepaid leases or IRUs.

> A key benefit of such long-term arrangements is that they allow health care providers to 'scale up' bandwidth as their needs increase…They also can yield lower prices and can provide longer-term price stability for health care providers. These arrangements also may provide vendors the incentive to deploy broadband connections where they do not exist, or to upgrade current facilities to higher bandwidths.[16]

Conclusion

It is important to note that creating incentives for telecom providers to deploy or enhance broadband connections in rural America benefits all telecommunications consumers, not just rural health care providers. On the other hand, when rural health care providers construct their own networks, they remove key anchor institutions (and revenues) from the public network, thereby increasing the cost of investment, and providing *disincentives* for further

[14] *Id*. Sec. IV.d. MTA also supports proposed reforms regarding use of consortia and inclusion of urban sites in consortia as discussed in Sections I and II.
[15] *Id*. fn. 32.
[16] *Op cit*. (WCB Report) p. 33.

broadband investment in public network infrastructure. By funding infrastructure construction through the rural health care program, the Commission effectively removes anchor institutions from the public network, increases the cost of future investment, thereby reducing investment and raising rates for those left using the public network, and discouraging economic development opportunity for rural America.

The Commission's Pilot Program Order, as well as the National Broadband Plan, cite the advantages of leveraging existing network facilities. The National Broadband Plan, for example, states,

> Due in large part to private investment and market-driven innovation, broadband in America has improved considerably in the last decade. More Americans are online at faster speeds than ever before…[T]he role of government is and should remain limited…Instead of choosing a specific path for broadband in America, this plan describes actions government should take to encourage more private innovation and investment.[17]

The 2006 *Pilot Program Order* expected rural health care providers to "present a strategy for aggregating the specific needs of health care providers…and *leveraging existing technology* to adopt the most efficient and cost effective means of connecting those providers."[18] (Emphasis added.)

In summary, the Telecommunications Act does not authorize the Commission to use universal service health care program funds for construction of network infrastructure. The Commission's own policies have reinforced the reasonableness of the policy adopted by Congress.

Respectfully submitted,

/s/

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[17] Federal Communications Commission. Connecting America: The National Broadband Plan. Rel.: March 16, 2010. Chapter 1, pp. 3-5

[18] *In the Matter of Rural Health Care Support Mechanism*. WC Docket No. 02-60; FCC 06-144. Order. Adopted: September 26, 2006. ¶16.